

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **42660**BIRTH NO. **92568-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10879**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Ill. b. COUNTY Madison			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN Madison		8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital				d. STREET ADDRESS (If rural, give location) 817 Iowa			
3. NAME OF DECEASED (Type or Print) a. (First) Steven		b. (Middle) Arin		c. (Last) Murphy		4. DATE OF DEATH (Month) (Day) (Year) 11 26 54	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH 11-25-54	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Frederic Jackson Murphy			13b. MOTHER'S MAIDEN NAME Dolores Jeanne Wadlow			14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dolores Jeanne Murphy, 817 Iowa			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity - 28 weeks ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) atelectosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		7625	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-26 , 19 54 , to 11-26 , 19 54 that I last saw the deceased alive on 11-26 , 19 54 , and that death occurred at 9:25 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Theodore M. Meiner, M.D.				23b. ADDRESS Firmin Desloge Hospital		23c. DATE SIGNED 11-29-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 11-27-54		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Madison, Ill.	
DATE REC'D BY LOCAL REG. NOV 29 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lahey F.H., Madison, Ill.			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

.....
working under my personal supervision.

Student
Student Embalmer

Signed

Not Embalmed

Licensed Embalmer No.

2200

P. O. Address

St Louis, Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.